Fiscal Narrative
Proposed Impact Certification and OSBM Fiscal Note

Amendment of Rule 10A NCAC 28C. 0201,
State Facility Environment

Agency: DHHS/ Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Impact:

Federal Impact:	Yes – $1,000
State Impact:	Yes – $81,700 first year; $78,200 thereafter
Local Government Impact:	No
Private Sector Impact:	No
Substantial Economic Impact:	No

Total Projected Expense - $82,700 first year; $79,200 thereafter

Authority: G.S. §143B-147(a)(1)

I. Overview:

It is proposed that Rule 10A NCAC 28C .0201 be amended to remove the requirement that the state must provide for adequate areas that are accessible to patients/residents who wish to smoke tobacco at the state operated facilities of the North Carolina Department of Health and Human Services (DHHS). See Appendix for proposed rule amendment.

II. Rationale:

The health and safety of patients/residents and staff in facilities operated by the DHHS is one of its highest priorities. Pursuant to G.S. §§130A-491 and 143, Article 64, smoking is not allowed in state government owned buildings. Thus, the buildings at all State operated facilities are smoke-free. However, pursuant to this rule, there must be areas for smoking at state owned facilities. Although there are limitations on the locations where smoking can take place on campus, tobacco smoking remains prevalent among patients. As such, smoking continues to impose health risks to those who smoke and those who do not. In addition to being the leading contributor of a 25 year premature death rate in individuals with mental illness, smoking interferes with patient recovery/habilitation and factors into aggressive behavior. In order to eliminate these negative factors, smoking will no longer have a role in the treatment/habilitative setting and open the door to improved patient/resident and staff health.

The Commission for Mental Health, Developmental Disabilities and Substance Abuse Services is proposing to remove 10A NCAC 28C. 0201(a)(4), which requires the provision of accessible areas for clients who wish to smoke tobacco and areas for non smokers as requested. To operationalize this change in a timely manner each facility must submit a smoking cessation plan

that outlines a carefully planned and executed strategy to ensure that patients/residents and staffs are provided:

- Ample notice of the new policy;
- Quality education about the benefits of quitting smoking;
- Medical treatment to support smoking cessation; and
- Adequate support for smoking cessation.

III. Rulemaking Authority:

The Commission has rulemaking authority for the subject matter of the proposed amendment pursuant to G.S. 143B-147(a)(1).

IV. Analysis of Fiscal Impact:

Implementation of this amendment will allow DHHS state-operated facilities, including the three state psychiatric hospitals, three alcohol and drug abuse treatment centers (ADATCs), three developmental centers, and three neuromedical treatment centers, to eliminate use of tobacco products on their campuses by patients/residents, staff, and visitors, thus creating a smoke-free environment.

COSTS:

On August 21, 2008, the Commission for MH/DD/SAS approved the use of a pilot program at Broughton Hospital, wherein all patients and staff participated in a smoke-free campus pilot program. The Walter B. Jones facility joined the pilot program in August 2009, following approval by the Commission. Anticipated costs for this rule change are based upon the costs incurred administering these pilot programs.

The Division does not anticipate the need for any additional staff in order to implement the smoke-free campuses. All campuses currently provide patient counseling for smoking cessation and provide programming. The principal cost accounted for within this fiscal note is for the provision of smoking cessation treatment for patients in the psychiatric hospitals and ADATCs in the form of an incremental increase in nicotine replacement therapy (NRT) over what is currently being used. Costs for such therapy at the developmental and neuromedical treatment centers will be much lower since there are very few newly admitted clients who smoke.

Training and Planning Costs

Support groups for patients going through smoking cessation will be provided at no additional cost. These support groups are already part of the existing program in each facility and represent the medical standard of care. The support groups will continue to be led by existing facility staff, and no additional staff will be hired. However, there will be additional costs related to training for leading smoking cessation and wellness groups, which is being conducted for staff from each hospital and ADATC facility. Training is comprised of a 13 week wellness curriculum for patients and will last for 7 hours. Training is provided through a federal grant administered by the Division of Public Health (DPH). Training costs are estimated to cost less than $1,000. It is anticipated that this training will be provided annually to ensure that additional staff can be trained at each facility. In addition, the cost of staff time and travel to attend this training is about $2,700 for 12 staff with an average total compensation of $25.45 per hour for 8 hours (7 hrs. of

training and 1 hour for travel time). The training estimate also includes an anticipated $288, approximately, in travel reimbursable expenses.

Information on the facilities' smoking policies will be provided as patients enter the facilities. Patients will be assessed and treatment based upon the results of the assessments; an individualized plan for meeting goals around nicotine dependence will be developed. The counseling and NRT are intervention strategies that can be used as part of an individualized treatment plan for smoking/nicotine dependence. Questions regarding dependencies are already part of individualized plans of treatment. Nicotine dependence is also addressed in the patient's discharge planning. It is anticipated that it will take approximately the same amount of time for discharge planning as initial treatment planning to complete, as questions regarding physical health are already part of the standard of medical care.

Nicotine Replacement Therapy Costs

Annual NRT costs are detailed in Table 1 on the following page and are based on actual incurred costs by each facility in first quarter of SFY 2012-2013. In recent surveys it was determined that 82% of clients admitted to ADATCs smoked, and from a recent Smoke-Free campus pilot at Broughton Hospital it was determined that 61% of clients smoked. These smoking rates are also consistent with those published in national literature.[1]

Current best practice for NRT suggests treatment for 90 days. In most cases a complete course of treatment cannot be provided as patients are discharged prior to their completion of a smoking cessation program. It is also important to note that voluntary smoking cessation programs already existed, and approximately 40% of patients who smoke participated in prior to rule change. Additionally, there is some reduction in the number of individuals treated with NRT as approximately 16% refuse the treatment. There are no NRT costs associated with the percentage of individuals who would have participated in a prior existing program, nor those who opt to quit "cold turkey" or otherwise refuse nicotine patches.

Actual dispensing and administration costs have been collected by facility for first quarter of SFY 2012-2013 (see Table 1 below). Medication costs range between $1.60 and $2.10 per patch and approximately $0.43 in administration costs of each patch. Extrapolating from this information for one quarter, the agency estimates that annual NRT costs would amount to about $75,500 [= (15,361+3,513) × 4].

[1] *Technical Report on Smoking Policy and Treatment in State Operated Psychiatric Facilities, NASMHPD Medical Directors Council Parks, J. and Jewell P., October, 2006.*

Table 1. Nicotine Replacement Therapy Costs Incurred by State Facilities in July-September, 2012

Facilities	Cost Per Nicotine Patch			# Nicotine Patches dispensed in 3 month period			Cost of 7 mg Patches	Cost of 14 mg Patches	Cost of 21 mg Patches	Total cost for patches July-Sept. 2012	# Patients treated in 3 month period	Admin. Costs Per Treated User
	Cost 7 mg	Cost 14 mg	Cost 21 mg	# 7 mg	#14mg	# 21 mg						
Broughton	$1.78	$1.78	$1.78	265	385	331	$472	$685	$589	$1,746	75	$420
CRH	$1.71	$1.71	$1.60	483		744	$826	$0	$1,190	$2,016	121	$525
Cherry		$2.10	$2.10	0	157	279	$0	$330	$586	$916	22	$187
WBJ	$2.07	$2.07	$2.07	154	196	2,090	$319	$406	$4,326	$5,051	251	$1,044
JFK ADATC	$1.78	$2.00	$1.78	93	373	2,346	$166	$746	$4,176	$5,087	N/A	$1,204
RJB ADATC	$1.71	$1.71	$1.60	149		110	$255	$0	$176	$431	44	$111
JIRDC	$2.10			0	0	0	$0	$0	$0	$0	0	-
Murdoch	$2.10			17	0	0	$36	$0	$0	$36	1	$7
Caswell	$2.10			0	0	0	$0	$0	$0	$0	0	-
BMNMTC	$2.10			0	0	0	$0	$0	$0	$0	0	-
Longleaf	$2.10	$2.10	$2.10	0	16	21	$0	$34	$44	$78	1	$16
O'Berry	$2.10			0	0	0	$0	$0	$0	$0	0	-
Totals				**1,161**	**1,127**	**5,921**	**$2,072**	**$2,200**	**$11,088**	**$15,361**	**515**	**$3,513**

Signs/Advertising Costs

Costs for additional "No Smoking" signs will be minimal. Pursuant to the existing rule language, each facility (not including pilots) currently had designated smoking areas. Most of their campus' locations are already appropriately marked as "No Smoking" areas. Signage will be installed in the areas in each state facility campus that lack signs (the previously designated smoking areas) to inform patients/residents, staff, and visitors of the smoke-free campus status. Cost of signage estimate is based on actual costs of signage incurred by Broughton Hospital during the pilot. These costs seem typical and the assumption similar costs at each additional state facility would project the costs to be approximately $3,500 ($293.70 X 12 facilities = $3,524). The needs for signs will be on a one-time basis and will not be a recurring cost in subsequent years of smoking cessation program.

Revenue Losses

Depending on the impact of this rule change on prolonged smoking cessation, the state might incur small losses in tobacco excise revenue. The current excise per pack is $0.45 and data suggest the average smoker smokes about half a pack a day, which could lead to a loss of about $160 per person who quits per year. Also, the tobacco industry might see a loss in their profits, however, given the small fraction of the population that would be affected, this impact would be insignificant. The agency does not have enough information or data to be able to estimate how many patients would continue to the cessation after being discharged from state facilities.

BENEFITS:

The proposed amendment to rule 10A NCAC 28C.0201 eliminates the requirement for state operated healthcare facilities to provide areas accessible to clients who wish to smoke tobacco. Elimination of this requirement will allow the facilities to create smoke-free environments. Since 1992, when Joint Commission imposed regulatory standards around smoking in hospitals, American general hospitals have been smoke free. Other healthcare facilities, including psychiatric hospitals, have generally lagged behind in establishing smoke-free environments.

The advantages of establishing a smoke-free environment in state-operated facilities are self-evident. In addition, in behavioral health facilities, a tobacco free environment can be expected to improve patient focus on therapeutic activities and improve the effects of medication and other treatment. These benefits are not quantifiable as the dependency upon nicotine and effects of treatment on each client are highly variable.

It is important to note that although it is hoped that individuals continue their smoking cessation programs after being discharged from state facilities, it isn't a requirement of their treatment. This rule applies only to smoking cessation in State run facility environments. It is understood that many, if not most, individuals that undergo nicotine replacement therapy in these state facilities may not continue the smoking cessation regime upon discharge. Due to this, long term benefits to clients are not calculated nor included in this fiscal note.

To the extent the change leads to prolonged cessation, current smokers could incur savings from no longer expending income on tobacco products.

A summary of estimated impacts from the proposed rule change is presented in Table 2 below.

Table 2. Impact Summary

Affected party	Impact	
COSTS	**$82,700**	**Total Costs in 1st year**
State Gov't	***$81,700***	***Total state gov't cost 1st year***
Training and Planning	$2,700	(recurring)
NRT administration	$75,500	(recurring)
Signs	$3,500	(non-recurring)
Tobacco excise revenue loss	Unquantified	
Local Gov't	None	
Federal Gov't	$1,000	(recurring)
Private	None	(minor impact on tobacco sales)
BENEFITS	Unquantified potential health benefits and savings on smoking products	

APPENDIX

10A NCAC 28C .0201 is proposed for amendment as follows:

10A NCAC 28C .0201 STATE FACILITY ENVIRONMENT

(a) The State Facility Director shall assure the provision of an esthetic and humane environment which enhances the positive self-image of the client and preserves human dignity. This includes:

(1) providing warm and cheerful furnishings;

(2) providing flexible and humane schedules; and

(3) directing state facility employees to address clients in a respectful ~~manner; and~~ manner.

~~(4) providing adequate areas accessible to clients who wish to smoke tobacco and areas for non-smokers as requested.~~

(b) The State Facility Director shall also, to the extent possible, make every effort to:

(1) provide a quiet atmosphere for uninterrupted sleep during scheduled sleeping hours; and

(2) provide areas accessible to the client for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment team.

History Note: *Authority G.S. 122C-51; 131E67; ~~143B-147;~~ 143B-147(a)(1);*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989.